

Virtual Clinic OpenEyes for Nurses/Technicians and Health Care Assistants (User Manual)

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Aims

This session is designed to introduce delegates to OpenEyes by presenting Healthcare professionals the technology to be able to document the clinical journey of patients under their care. The session aims to give the best practices on better patient care and management.

The Nurse/ Technicians /Health Care Assistants will use mainly episode and events screen within OpenEyes for diagnosis, examinations and prescriptions.

The following features are included in this course:

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Documentation History

Date	Version number	Revision details	Written by	Approved by
24/11/2014	0.1	First draft of document	Victoria Aina	OpenEyes Programme Office
29/01/2014	0.2	Removal of Virtual Clinic screen shots and access description. Description of how to add patients to VC list.	Victoria Aina	OpenEyes Programme Office and

Document Status

This is a controlled document.

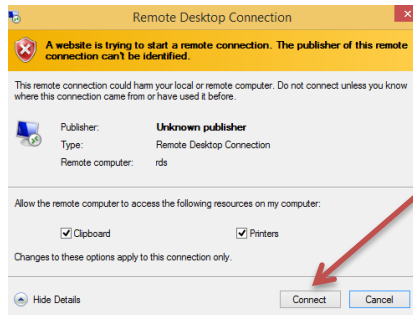
This document version is only valid at the time it is retrieved from controlled file store, after which a new approved version will replace it.

On receipt of a new issue, please destroy previous issues (unless a specified earlier issue is base lined for use throughout the programme

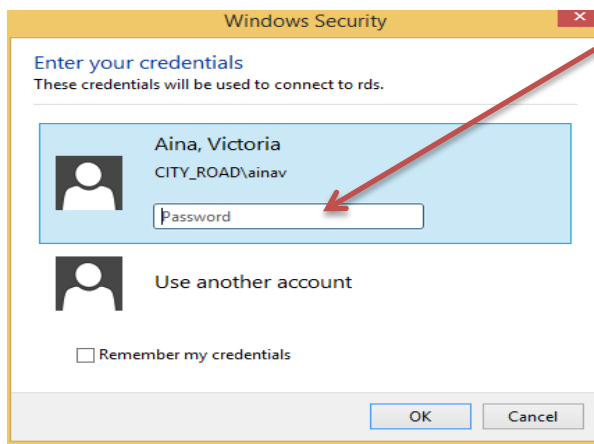
Logging on and Getting Started

The OpenEyes login page is case sensitive.

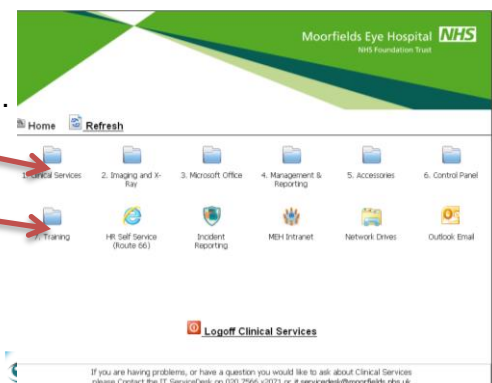
1. Select the clinical services link within the intranet.
2. The remote desktop pop up box opens, select the grey **Connect** button situated within the box.



3. Within the Windows Security pop up box enter '**Password.**'



4. Select Clinical services folder (for the live environment).
5. Select the Training folder (Training environment).



6. Launch **Open Eyes** by selecting (double clicking) the **OpenEyes Training** Icon.
7. Delegates will now have entered the OpenEyes page and be able to view the login page.
8. Enter Username and Password then select the blue login button **Login**.

If demographic details need to be altered, this action can currently be altered/updated in PAS.

Patient demographics

Links takes you to last event recorded.

Patient Clinical Summary.

Minimum Legacy Data Set.

Inform delegates that it is expected that doctors and optometrists enter the minimum legacy data sets into the relevant fields located on the summary page.

Ophthalmic Diagnosis

Other ophthalmic diagnoses		
Date	Diagnosis	Actions
14 Apr 2013	Right Age related macular degeneration	Remove
14 Apr 2013	Right Low tension glaucoma	Remove
14 Apr 2013	Right Pigment dispersion syndrome	Remove
14 Apr 2013	Right Acute angle-closure glaucoma	Remove
14 Apr 2013	Right Secondary glaucoma	Remove
2014	Right Acute angle-closure glaucoma	Remove
Add Ophthalmic Diagnosis		

1. Select the [Add Ophthalmic Diagnosis](#) button.
2. From the list of 'Commonly used diagnosis' linked to the speciality (firm) select appropriate diagnosis or Select a SNOMED term by typing into the dynamic text box .

Diagnosis:

or type

Eye: ☒ Right ☐ Both ☐ Left

Date diagnosed:

[Save](#) [Cancel](#)

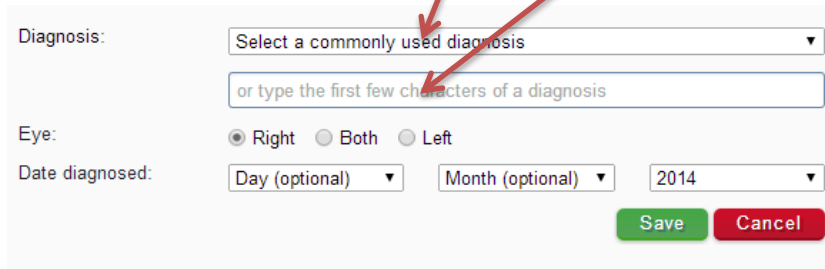
3. Enter date of diagnosis.
4. Select the green [Save](#) button to save diagnosis entered.
5. Select [Cancel](#) to discard information entered in the diagnosis area.

Systematic Diagnosis

1. Select [Add Systemic Diagnosis](#) button.

Systemic Diagnoses		
Date	Diagnosis	Actions
2013	Diabetes mellitus type 1	Remove
14 Apr 2013	Myocardial infarction	Remove
14 Apr 2013	Marfan's syndrome	Remove
Add Systemic Diagnosis		

2. Select the appropriate '**Commonly used diagnosis**' linked to the speciality (firm) from the drop down menu or Select a SNOMED term by typing into the dynamic text box.



Diagnosis:

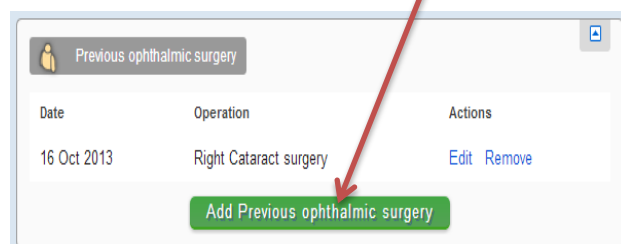
Eye: ☒ Right ☐ Both ☐ Left

Date diagnosed:

3. Enter date of diagnosis.
4. Select the green button.

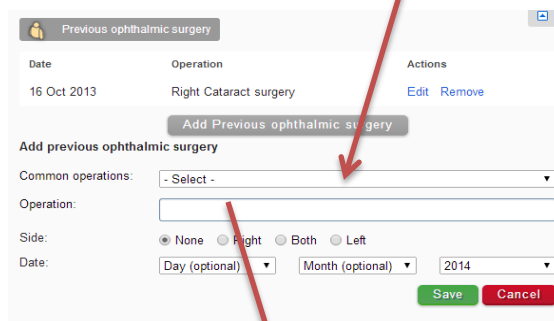
Previous Ophthalmic Surgery

1. Select button.



Date	Operation	Actions
16 Oct 2013	Right Cataract surgery	Edit Remove

2. Select the appropriate '**Common operations**' option from the drop down menu or enter free text in the '**Operation**' box below.



Add previous ophthalmic surgery

Common operations:

Operation:

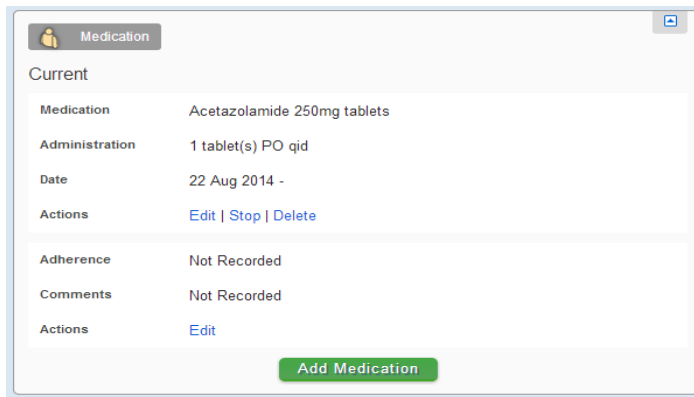
Side: ☒ None ☐ Right ☐ Both ☐ Left

Date:

3. Select the appropriate '**side**' from the option of ariel circles. (*only select if appropriate*)
4. Enter the date of operation.
5. Select the green button.

Medication

1. Select the **Add Medication** button.



The screenshot shows a 'Medication' form with a 'Current' section. The fields are as follows:

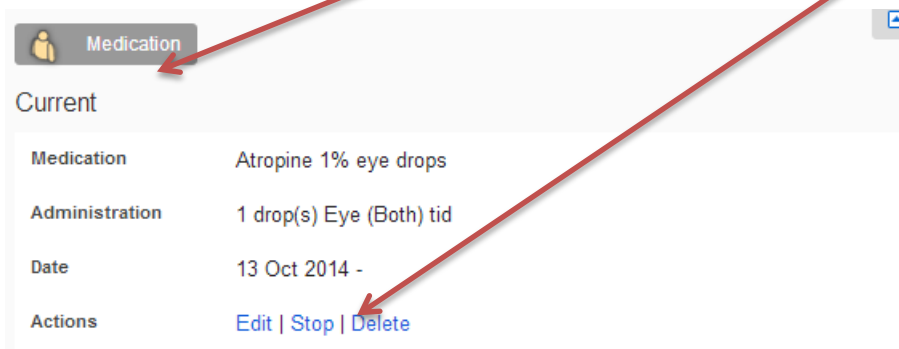
Field	Value
Medication	Acetazolamide 250mg tablets
Administration	1 tablet(s) PO qid
Date	22 Aug 2014 -
Actions	Edit Stop Delete
Adherence	Not Recorded
Comments	Not Recorded
Actions	Edit

At the bottom of the form is a green **Add Medication** button.

2. Select medication from the drop down menu.
3. If the medication required is not listed, search the formulary in the dynamic field below and Select a SNOMED term by typing into the dynamic text field for any other.
4. Enter the patient dose. *This field is free text*
5. Select the appropriate **'route'** from the drop menu.
6. Select the appropriate **'frequency'** from the drop down menu.
7. Select date patient began using medication or select today's date by clicking the **'Blue button'** located on the right hand side of the box.
8. Select current state of medication. *Is the patient currently using the medication.*

Stop, Edit or Delete Medication

1. Within the medication box, under the **'current'** subheading.
2. Identify the required medication.
3. Select the appropriate action from the **'Actions'** field: **Edit|Stop|Delete**.



The screenshot shows the same 'Medication' form, but with different data. Red arrows point to the 'Medication' field and the 'Actions' field.

Field	Value
Medication	Atropine 1% eye drops
Administration	1 drop(s) Eye (Both) tid
Date	13 Oct 2014 -
Actions	Edit Stop Delete

Stop

1. To **'Stop'** medication ensure the following fields are completed, **'date stopped'** and **'reason stopped'** select the appropriate option from the drop-down menu then select green **Stop** button .

Stop Medication

Medication: Atropine 1% eye drops

Date stopped: 13 October 2014

Reason for stopping: - Select -

Stop **Cancel**

2. The medication will move from the **'current'** medication sub heading to the **'previous'** medication subheading.

Medication

Current

Medication	Atropine 1% eye drops
Administration	1 drop(s) Eye (Both) tid
Date	13 Oct 2014 -
Actions	Edit Stop Delete

Previous

Medication	Apraclonidine 0.5% eye drops
Administration	1 drop(s) Eye (Both) tid
Date	13 Oct 2014 - 13 Oct 2014
Actions	Edit Delete
Adherence	Not Recorded
Comments	Not Recorded
Actions	Edit

Add Medication

Edit

5. To **'Edit Medication'** select **'edit'** from action field.

Edit medication Add Medication

Medication: Acetazolamide 250mg tablets
- Select -
or search formulary

Dose: 1 tablet(s)

Route: PO

Frequency: qid

Date from: 22 August 2014

Current: ☒ Yes ☐ No From today

Save Cancel

6. Select the required **'medication'** from the drop down menu or Select a SNOMED term by typing into the dynamic text box.
7. Select the green Save button located bottom left hand area of the medication area to save any changes.
8. Select the Cancel button located on the right hand side of the medication area not to save changes

Delete

1. To delete medication select **'delete'** from action field.
2. From the pop up box, select the Remove medication red button from within the pop up box.

Confirm delete medication

×

WARNING: This will remove the medication from the patient record.

Are you sure you want to proceed?

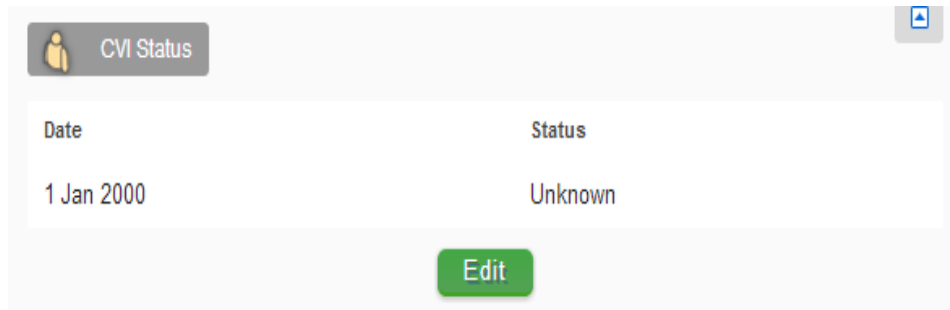
Remove medication Cancel

3. The medication will be removed from the list of medication.

CVI Status

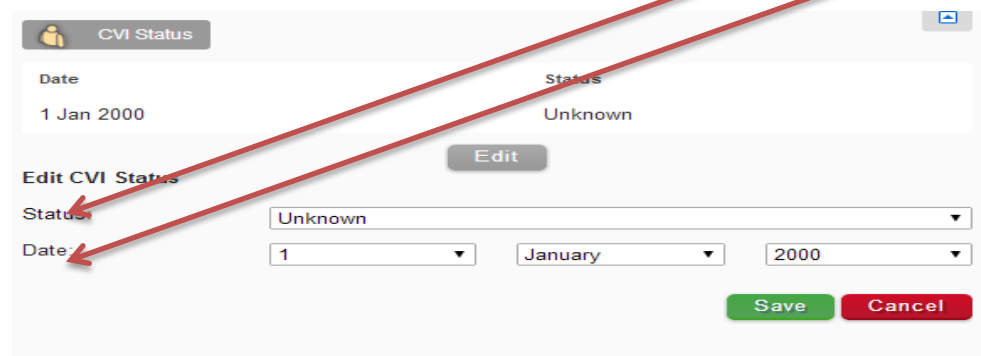
Doctors are required to record the current visual impairment of their patient. Note a default date '1 Jan 2000' and status 'Unknown' is pre-populated in the fields.

1. To add or edit the CVI status of a patient click on the green **Edit** button.



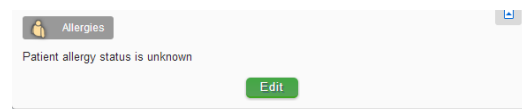
The screenshot shows a form titled 'CVI Status' with a patient icon. It contains two fields: 'Date' with the value '1 Jan 2000' and 'Status' with the value 'Unknown'. Below these fields is a green 'Edit' button.

2. Under the 'Edit CVI Status' subheading complete the following fields 'Status' and 'Date' by selecting the appropriate fields from the drop down menu.
3. Select the green **Save** button so save changes.



The screenshot shows the 'Edit CVI Status' form. It has a subheading 'Edit CVI Status' and an 'Edit' button. Below are two dropdown menus: 'Status' (currently set to 'Unknown') and 'Date' (currently set to '1 January 2000'). At the bottom are 'Save' and 'Cancel' buttons. Red arrows point from the instructions to the 'Status' and 'Date' dropdowns.

Allergies



The screenshot shows a form titled 'Allergies' with a patient icon. It contains the text 'Patient allergy status is unknown' and a green 'Edit' button.

Within the 'Allergies' field select the green **Edit** button

1. Select the appropriate allergy from the 'Add allergy' field.

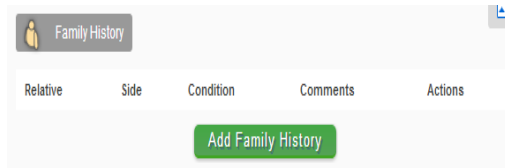


The screenshot shows the 'Allergies' form with the 'Edit' button selected. Below the 'Edit' button is a checkbox labeled 'Confirm patient has no allergies' and a dropdown menu labeled 'Add allergy' (currently set to '-- Select --'). At the bottom are 'Save' and 'Cancel' buttons. A red arrow points from the instruction to the 'Add allergy' dropdown.

2. Select the green **Save** button, to save changes.

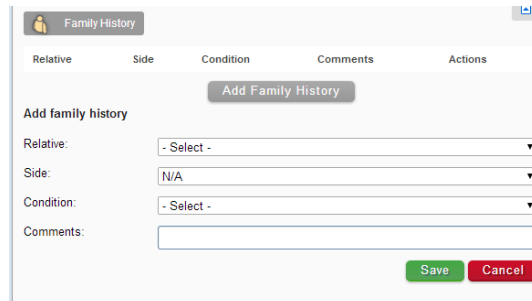
Family History

1. To complete family history select the green **Add Family History** button.



The image shows the top portion of the 'Family History' form. It includes a header bar with a person icon and the text 'Family History'. Below this is a table with five columns: 'Relative', 'Side', 'Condition', 'Comments', and 'Actions'. At the bottom of the table is a green button labeled 'Add Family History'.

2. select the appropriate options from the drop down menus to complete the following fields **'Relative,' 'Side' and 'Condition'**.

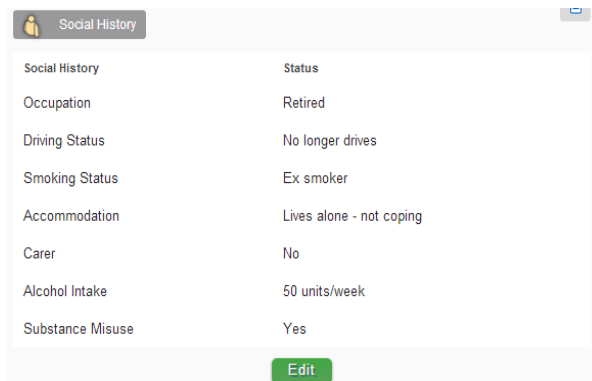


The image shows the 'Add family history' section of the form. It contains four fields: 'Relative' with a dropdown menu showing '- Select -', 'Side' with a dropdown menu showing 'N/A', 'Condition' with a dropdown menu showing '- Select -', and 'Comments' with a text input field. At the bottom right are green 'Save' and red 'Cancel' buttons.

3. Select the green **Save** button to save changes.

Social History

1. To complete the Social History select the green **Edit** button.



The image shows the 'Social History' form. It has a header bar with a person icon and the text 'Social History'. Below this is a table with two columns: 'Social History' and 'Status'. The table contains the following rows: 'Occupation' (Retired), 'Driving Status' (No longer drives), 'Smoking Status' (Ex smoker), 'Accommodation' (Lives alone - not coping), 'Carer' (No), 'Alcohol Intake' (50 units/week), and 'Substance Misuse' (Yes). At the bottom right is a green button labeled 'Edit'.

2. Select the appropriate option from the drop down menu to complete the following fields: **'Occupation,' 'Driving Status,' 'Smoking Status,' 'Accommodation,' 'Carer,' and 'Substance Misuse'**
3. Complete the following free text fields: **'Comments,' and 'Alcohol Intake'**.

- On the right hand side of the main screen under the '**All Episodes**' subheading select the blue '**Create episode/add event**' link.

All Episodes open 1 | closed 0

Start Date	End Date	Firm	Subspecialty	Eye	Diagnosis
Ophthalmology					
24 Jun 2014		Brookes John	Glaucoma	No diagnosis	No diagnosis

[Create episode / add event](#)

Other ophthalmic diagnoses

Date	Diagnosis	Actions
Add Ophthalmic Diagnosis		

Systemic Diagnoses

Date	Diagnosis	Actions
Add Systemic Diagnosis		

Episodes and Events

An episode is an on-going period of clinical care. A patient can have more than one episode of care at the same time at which point they may be under the care of a different consultant/and or speciality (firm).

An 'Open Episode' (current) has a start date but no end date. A 'Closed Episode' has a start and end date. This represents a period of clinical care that has now finished for a particular specialism(firm) led by a specific consultant.

All Episodes open 3 | closed 0

Start Date	End Date	Firm	Subspecialty	Eye	Diagnosis
Ophthalmology					
8 May 2013		Brookes John	Glaucoma	Right	Aspergillus otomycosis
23 Jul 2013		Hamilton Robin	Medical Retinal	No diagnosis	No diagnosis
30 Oct 2013		Maurino Vincenzo	Cataract	Right	Cataract

An Event is any activity that takes place during a patient appointment e.g.; booking a procedure, examinations, Clinic letters. This is recorded within open eyes.

Episodes and Events' summary screen

1. The 'Episodes and Events' summary screen opens.

Summary

Glaucoma

Overview

Male, 44, CVI status: Sight Impaired, Driving status: No longer drives

Principal diagnosis:

Primary angle-closure glaucoma

Principal eye:

Right

Refraction

0.00/0.00 @ 176° Ophthalmologist 0.00/0.00 @ 0° Auto-refraction

CCT

Not recorded Not recorded

IOP1

10 mmHg 13 mmHg

Glaucoma Management Plan

Clinio Internal	12 months
Photo	12 months
OCT	12 months
Visual Fields	12 months
Gonio	Not required
HRT	12 months

The 'Summary Screen' displays the following information:

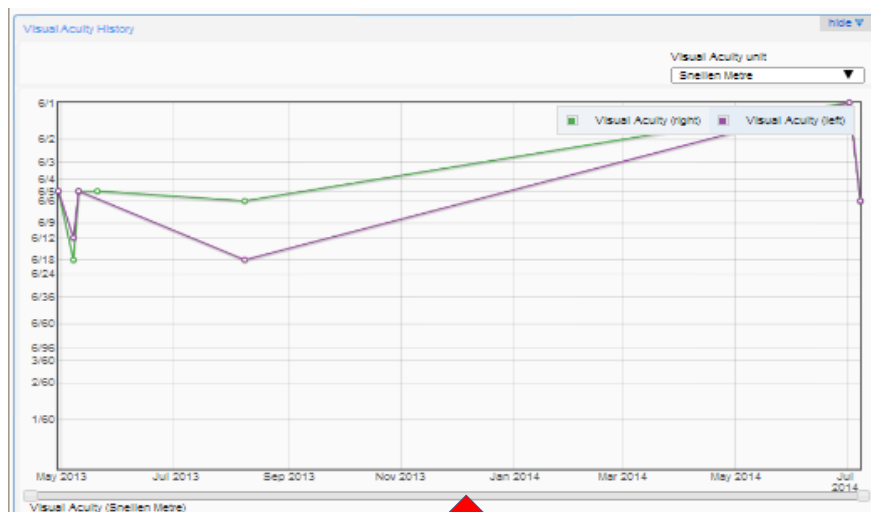
- Overview
- Principal Diagnoses
- Refraction
- CCT
- IOP
- Comments
- Clinic Interval
- Investigations
- Visual Field progression and last Visual fields
- Glaucoma Management Plan extracts
- Target IOP

Graph of IOP History



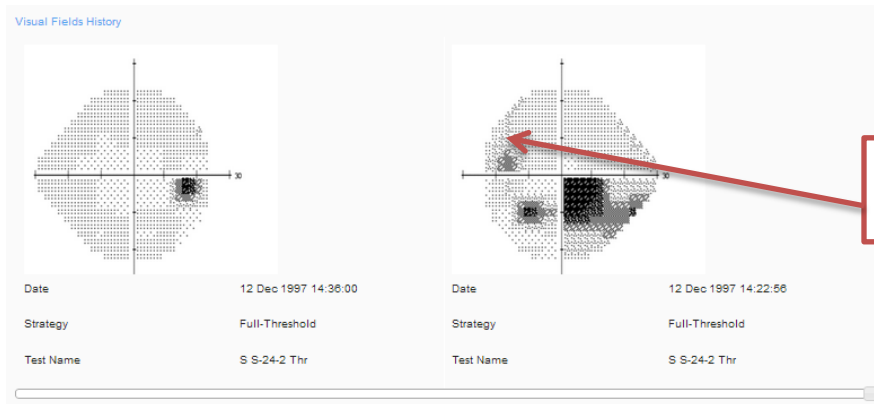
Move the bar to view history of data

Graph of Visual Acuity History



Move the bar to view history of data

Visual Fields History



Select image to zoom into detail view

Move the bar to view history of data

Episode Details

Start Date:	End date:
4 Jun 2014	(still open)
Subspecialty:	Consultant firm:
Glaucoma	Brookes John
Glaucoma: created by User User on 4 Jun 2014 at 12:43	
Episode Status:	
Post-op	

View episode details

View episode status

How to create an Episode

*How an Episode is created is dependent on the screen. If creating an Episode from the '**Patient Summary**' screen follow from step 1. If already in the '**Episodes and Events**' summary screen follow from step 2.*

1. On the right hand side of the 'Patient Summary' screen under the '**All Episodes**' sublink [Create episode / add event](#) link.

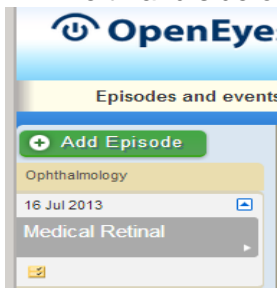
All Episodes

open 1 | closed 0

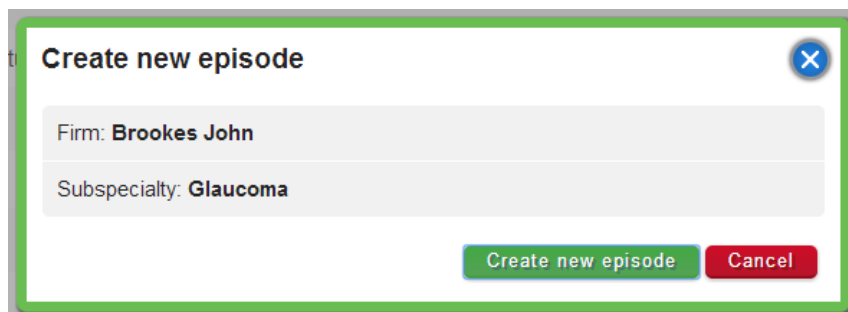
Start Date	End Date	Firm	Subspecialty	Eye	Diagnosis
Ophthalmology					
24 Jun 2014		Brookes John	Glaucoma	No diagnosis	No diagnosis

[Create episode / add event](#)

2. From the '**Episodes and Events**' summary screen select [+ Add Episode](#) located on the left hand side of the screen.



3. Select the green [Create new episode](#) button from the '**Create new episode**' pop up box to create new episode of care.



Create new episode ✕


Firm: **Brookes John**

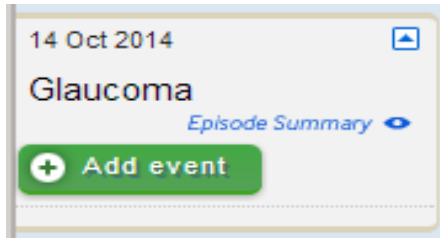
Subspecialty: **Glaucoma**

[Create new episode](#) [Cancel](#)

How to create an Event

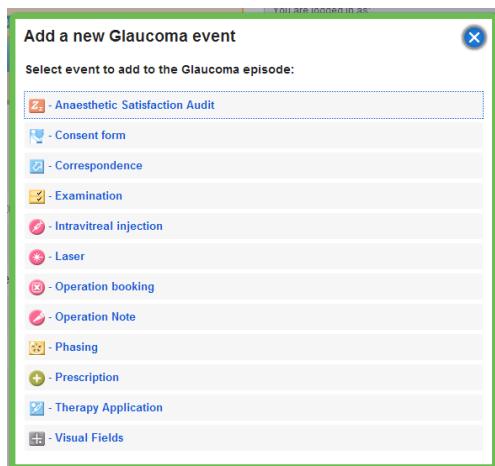
Ensure the correct firm/episode has been selected before adding or changing an event.

1. To the left of the Episodes and Events summary screen select the green  button, to add a patient '**Event.**'

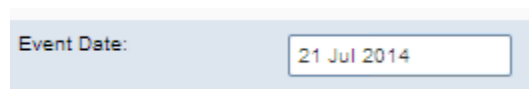


2. Select the  - Examination option from the '**Add a new event**' pop up box.

Depending on episode of care chosen this box subheading will display a different speciality.



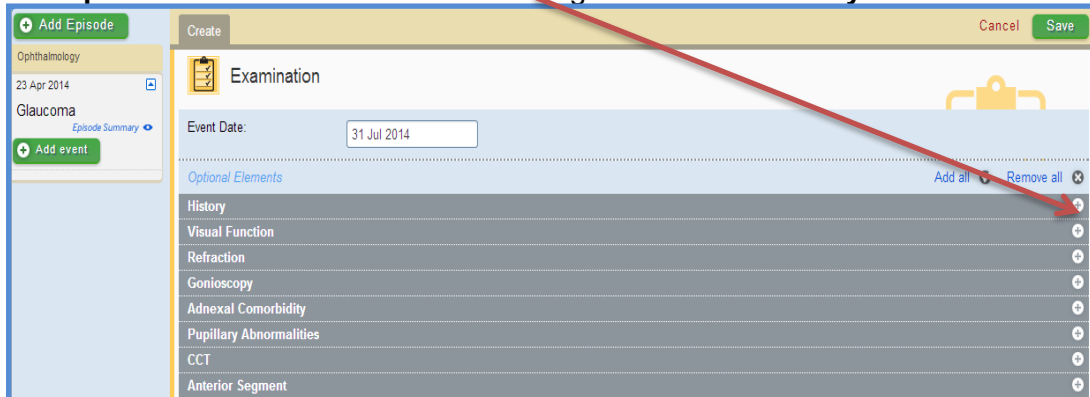
3. Change date to record for an event retrospectively these events will appear.



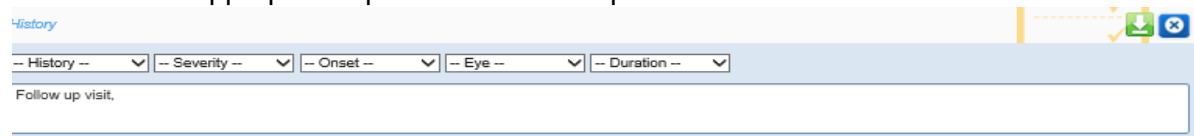
History Examination

Complete Step 3 if 'History' area of the examination form is not already open.

1. To the left of the Episodes and Events summary screen select the green **+ Add event** button, to add a patient event.
2. The '**Examination**' form opens. To add the '**History**' data scroll down to the grey '**Optional Elements**' and select the + sign beside the '**History**' label

The screenshot shows the 'Examination' form. On the left is a sidebar with 'Ophthalmology', '23 Apr 2014', and 'Glaucoma'. The main area has a 'Create' header with 'Cancel' and 'Save' buttons. Below is an 'Event Date' field set to '31 Jul 2014'. A section titled 'Optional Elements' contains a list of items: History, Visual Function, Refraction, Gonioscopy, Adnexal Comorbidity, Pupillary Abnormalities, CCT, and Anterior Segment. Each item has a plus sign to its right. A red arrow points to the plus sign next to 'History'. At the top right of the 'Optional Elements' section are 'Add all' and 'Remove all' buttons.

3. The '**History**' area of the examination form opens.
4. Select the appropriate options from the drop down menu or free text to enter the

The screenshot shows the 'History' section of the form. It has a title bar with a close button. Below the title bar are five dropdown menus: 'History --', 'Severity --', 'Onset --', 'Eye --', and 'Duration --'. Below these is a text input field with the placeholder text 'Follow up visit,'.

5. Select the green **Save** button on the top right hand side of the examination screen to save information entered.
6. Select **Cancel** to discard information entered

Visual Function Examination

Complete Step 3 if 'Visual Function' area of the examination form is not already open

1. To the left of the Episodes and Events summary screen select the green **+ Add event** button, to add a patient event.
2. The '**Examination**' form opens. To add '**Visual Function**' examination data scroll down to the grey '**Optional Elements**' and select the + sign beside the '**Visual Function**' label to enter data for '**Visual Function**.'
3. The '**Visual Function**' area of the examination form opens.
4. Enter information in the '**Visual Function**' comment box area.

The screenshot shows the 'Visual Function' section of the form. It has a title bar with a close button. Below the title bar are two identical input areas. Each area has a checkbox labeled 'RAPD' and a text input field below it. The first input field contains a single character 'I'.

5. Select the green **Save** button on the top right hand side of the examination screen to save information entered.
6. Select **Cancel** to discard information entered that is no longer required.

Visual Acuity Examination

Complete Step 3 if 'Visual Acuity' area of the examination form is not already open

1. To the left of the Episodes and Events summary screen select the green **+ Add event** button, to add a patient event.
2. The **'Examination'** form opens. To add **'Visual Acuity'** examination data scroll down to the grey **'Optional Elements'** and select the + sign beside the **'Visual Acuity'** label to enter data for **'Visual Acuity.'**
3. The **'Visual Function'** area of the examination form opens.

4. Select the appropriate option from the **'Visual Acuity'** drop down menu.

5. Select the appropriate **'Visual Acuity'** value from the drop down menu.

6. Select the appropriate option from the drop down menu.

7. Select the green **Save** button on the top right hand side of the examination screen to save information entered.
8. Select **Cancel** to discard information entered that is no longer required.

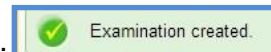
CCT examination

1. To the left of the Episodes and Events summary screen select the green **+ Add event** button, to add a patient event.
2. The '**Examination**' form opens. To add CCT examination data scroll down to the grey 'optional elements' and select the **+** sign beside the CCT label to enter data for CCT.

3. The '**CCT**' area of the examination form opens. Complete the necessary fields.

If both eyes are not being examined select the X button to close the eye examination field of the eye that is not being examined.

4. To save information entered select the green **Save** button located top right hand corner of the examination form.
5. Once saved the following message will be displayed.



Intraocular pressure Examination

Follow step 1 if 'Intraocular Pressure' area of examination screen not already open. If open follow from step 2.

1. To add the data from **Intraocular Pressure** examination scroll down to the grey **'optional elements'** and select the + sign beside the **'Intraocular Pressure'** label.
2. Select the green **Add** button located bottom left hand side of the **'Intraocular pressure'** area of the screen.

Time	mm Hg	Instrument	
15:24	10	Goldmann	Remove
15:24	Soft	Palpation	Remove

Add

3. Enter the mm Hg data.
4. Select the appropriate instrument.
5. Record any relevant comments into the box below.
6. Select the green **Save** button on the top right hand side of the examination screen to save information entered.
7. Select **Cancel** if information entered is not required to be saved.

Dilation

Follow step 1 if 'Dilation' area of examination screen not already open. If open follow from step 2.

Multiple dilation drugs can be recorded select add to enter additional dilatation.

1. To add the data from the **'Dilation'** examination scroll down to the grey **'optional elements'** and select the + sign beside the **'Dilation'** tab.
2. To record the data of the drops administrated to patient, select the appropriate drug from the drop down menu.

Dilation

--- Please select --- **Clear**

Time	Drug	Drops
12:03	Atropine 1%	2

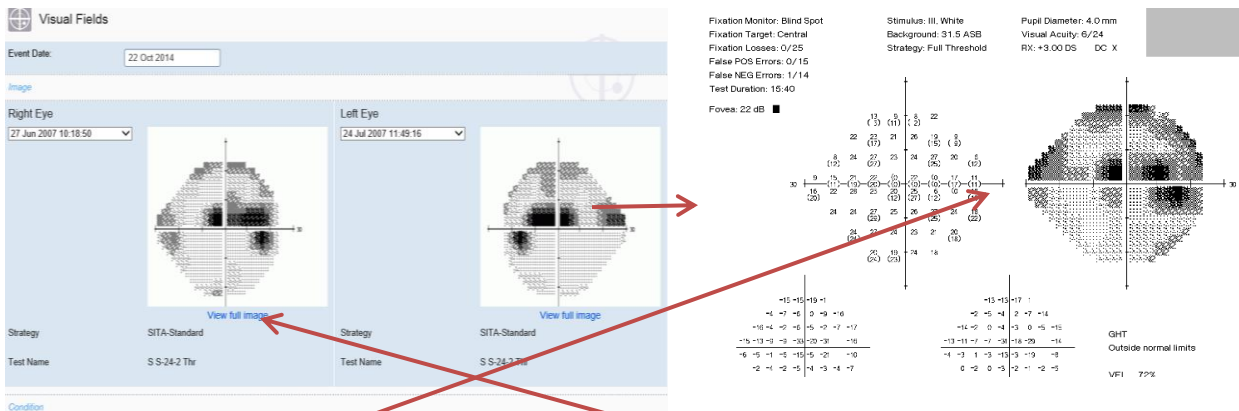
3. The time of administration is set automatically to the current time. To change click into the time box and type desired time to override the default time.
4. Select the number of drops administered from the drop down menu.
5. Select the green **Save** button on the top right hand side of the examination screen to save information entered.

Visual Fields Legacy Event

Ensure the appropriate event date is recorded within the 'Event Date' field.

1. To the left of the Episodes and Events summary screen select the **+ Add event** and select the **'Visual Field'** legacy Event.
2. The **'Visual Field'** event screen opens.
3. Select the appropriate option from the **'Right Eye'/'Left Eye'** drop down menu.

Only select options both eyes if historical image is required for both eyes.



4. To view the full image, select the **'view full image'** hyperlink.
5. The **'image'** will open in a separate screen.
6. Select the appropriate option from the **'ability'** drop down menu.
7. Select the appropriate option from the **'Glasses'** drop down menu.
8. Record any relevant comments in the **'Comments'** box.

Condition

Ability:

Glasses: ☐ Yes ☐ No

Comments

Comments:

Result

Result Assessment:

9. Select the appropriate option from the **'Results'** drop down menu.
10. Select the green **Save** button on the top right hand side of the examination screen to save information entered

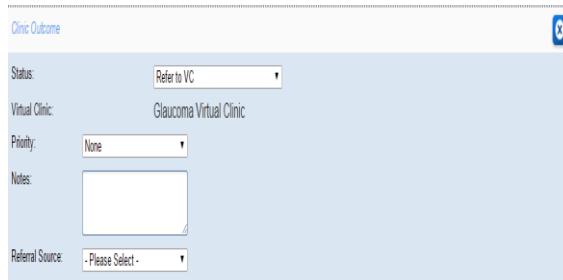
Add patient to Virtual Clinic Patient list

Data Sets are displayed in the Clinic.

1. To add a patient to the '**Virtual Clinic**' list scroll down to the grey '**optional elements**' and select the **+** sign beside the '**Clinic Outcome**' label.
2. Select the '**Refer to VC**' option from the '**Status**' drop down menu



3. A form opens. Select the appropriate priority (**red**, **amber** or **green**) option (as per clinic data sets) from the drop down menu.



4. Select the appropriate option from the '**Referral Source**' drop down menu.
5. Select the **Save** button located top right hand side of the examination screen to save information entered.
6. Select **Cancel** if information entered is not required to be saved

Logging Off

1. Select **Logout** from the tab located top right hand corner of the screen. *This can be seen from any screen within OpenEyes.*

